Accelerated Benefit Claim Form for Critical Illness

Submitted to Life Claims Department
P O Box 10466, Springfield Mo 65808-0466
Phone: (800) 615-7372

STATEMENT OF CLAIMANT

American National Insurance Company
American National Life Insurance Company of Texas
Garden State Life Insurance Company
Standard Life and Accident Insurance Company

NOTE: THE COVERED QUALIFYING EVENTS ARE LISTED ON PAGES 3 AND 4

Policy Number(s) _____ SSN _____

Name in full _____ Date of Birth _____

Other names used by Claimant (maiden, nicknames, alias, etc.) _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

1: What is the nature of your illness? _____

2. Date you first noticed symptoms? _____

3. Name of first doctor consulted _____ Address _____

4. When were you first treated for this condition? _____

5. I experienced a Qualifying Event on _____

6. Names and addresses of all physicians, hospitals, and/or institutions who have treated you for this condition (if additional space is needed, please use back of form).

Name	Address	Date of first visit

NOTE: If the form is not completed in full, it may be returned, which will cause a delay in the processing of the claim.

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other applicable federal and state privacy laws. You are not required to sign the authorization, but if you do not, your claim form may not be able to be evaluated or processed. Please sign and return this authorization with the claim form to the address on the first page of this claim package.

AUTHORIZATION

I have filed a claim for accelerated insurance benefits with AMERICAN NATIONAL INSURANCE COMPANY, AMERICAN NATIONAL LIFE INSURANCE COMPANY OF TEXAS, GARDEN STATE LIFE INSURANCE COMPANY, or STANDARD LIFE AND ACCIDENT INSURANCE COMPANY (the "Companies") on the life of _____.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, pharmacy, pharmacy benefit managers, group policy holder, benefit plan administrator, the Medical Information Bureau, government agency, and paramedical facility to provide the Companies, and their duly authorized representatives, data or records containing information regarding medical history and treatment including advice, care or treatment sought by me. The data or records may include information relating to my medical history, medical conditions, treatment, hospitalizations, including AIDS/HIV, or confinements, ailments and/or drug, alcohol, or tobacco usage and mental illness.

I also authorize any employer, law enforcement agency, financial institution or other individual or organization to provide the Companies, and their duly authorized representatives, data or records containing information regarding employment, income, driving records or other information necessary to evaluate and process the claim.

It is understood that the information obtained by this authorization will be used to evaluate this claim and may be transferred to any reinsurer, agency, insurance support organization or person employed by the Companies to assist with this purpose. I understand that when information that is covered by HIPPA is disclosed to an entity that is not subject to HIPPA, the information may be re-disclosed by the recipient and may no longer be subject to the protections of HIPPA. However, I understand that disclosed information may be re-disclosed only in accordance with other applicable federal and state privacy laws.

This authorization is valid for two years from the date below or the duration of this claim, whichever period is shorter. I understand I have the right to request a copy of this authorization and that a copy of this authorization will be sent to me if requested. A photographic or electronic copy of this form will be as valid as the original.

I may revoke this authorization in writing at any time except to the extent that the Companies have relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand that if I revoke this authorization or if I alter its content in any way, the Companies may not be able to evaluate or administer this claim and this may be the basis for denying this claim.

1) I have read the applicable state Claim Fraud Warning provided in this form. NEW YORK RESIDENTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation;

2) I am not currently subject to IRS required backup withholding as a result of failure to report all interest or dividend income;

3) I certify, under penalty of perjury that the information and Social Security Number(s) on this claim form are true and correct;

4) By furnishing forms to file for accelerated benefits the Companies do not waive any available legal defenses.

_____

Claimant's signature Date

_____

Please print Claimant's name

 DEFINITIONS

The covered Qualifying Events are:

Heart Attack (myocardial infarction) – The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart Attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack. The diagnosis of a Heart Attack must be made by a Physician board certified in Cardiology and based on the presence of:

1. associated new EKG changes which support the diagnosis; and,
2. elevation of cardiac enzymes above standard laboratory levels.

Stroke – A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis resulting in paralysis or other measurable neurological deficit which persists for 96 hours following the occurrence of the Stroke. Stroke does not include transient ischemic attacks. The diagnosis of a Stroke must be made by a Physician board certified in Neurology.

Invasive Cancer – A disease which is characterized by the presence and uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Invasive Cancer must be diagnosed by a pathological or clinical diagnosis. Invasive Cancer does not include:

1. any skin cancer, except invasive malignant melanoma into the dermis or deeper;
2. pre-malignant lesions, benign tumors, or polyps;
3. early prostate cancer diagnosed as T1N0M0 or equivalent staging; or,
4. carcinoma in-situ.

Diagnosis of End Stage Renal Failure – The irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.

Major Organ Transplant – The receipt by transplant of any of the following organs or tissues; heart, lung, liver, kidney, pancreas, small intestine or bone marrow. The Insured must be registered on the United Network of Organ Sharing.

Diagnosis of ALS (Amyotrophic Lateral Sclerosis) by a qualified Physician.

Blindness – The total and permanent loss of sight in both eyes as a result of disease or injury and results in a reduced life expectancy. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

Paralysis – The complete and permanent loss of use of two or more limbs through neurological injury for a continuous period of at least 180 days. Paralysis must be confirmed by a Physician board certified in Neurology.

Arterial Aneurysms - A localized widening (dilatation) of an artery, vein, or the heart. The diagnosis of an Arterial Aneurysm must be made by a Physician board certified in Cardiology.

Central Nervous System Tumors – Diagnosis of any abnormal solid growth involving the central nervous system (brain and/or spinal cord) by a Physician.

 CONTINUED

Major Multi-System Trauma – Any major accident or injury resulting in significant alteration of any three (3) body systems which requires hospitalization and extended rehabilitation, results in permanent impairment of the function and/or altered ability to perform Activities of Daily Living, and significantly alters the Insured's life expectancy. The Activities of Daily Living are:

• Bathing – including washing oneself by sponge bath, or in a tub or shower, including the task of getting into and out of the tub or shower.
• Continence – the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.
• Dressing – the ability to put on and take off all items of clothing and any necessary braces, fasteners, or artificial limbs.
• Eating – the ability to feed oneself by getting food into the body from a receptacle, such as a plate, cup, or table, or by a feeding tube or intravenously.
• Toileting – the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
• Transferring – the ability to move into and out of a bed, chair, or wheelchair.

Auto-Immune Deficiency Syndrome (AIDS) – Advanced HIV infection that is associated with an AIDS defining condition (P. carinii pneumonia, esophageal candidiasis, wasting, Kaposi's sarcoma, disseminated mycobacterium avium infection, tuberculosis, cytomegalovirus disease, HIV-associated dementia, recurrent bacterial pneumonia, toxoplasmosis, immunoblastic lymphoma, chronic cryptosporidiosis, Burkitt lymphoma, disseminated histoplasmosis, invasive cervical cancer and chronic herpes simplex) and has been diagnosed by a Physician.

Severe Disease of Any Organ – Severe Disease of Any Organ system is any illness that is life-threatening, requires inpatient hospital care and, and will significantly alter the Insured's life expectancy, as diagnosed by a Physician.

Severe Central Nervous System Disease – Severe disease of the central nervous system, brain and/or spinal cord, as diagnosed by a Physician that is life threatening and significantly alters the Insured's life expectancy, as diagnosed by a Physician. Severe Central Nervous System Disease includes, but is not limited to, progressive multiple sclerosis, Parkinson's Disease, Huntington's chorea and encephalitis which permanently alters a portion of the cerebrum.

Major Burns – The diagnosis by a Physician board certified in plastic surgery, that the Insured has sustained third degree burns covering at least 40% of the surface area of the Insured's body.

Loss of Limbs – The complete and permanent severance of two or more limbs through or above the elbow or knee joint due to trauma or accident and results in a reduced life expectancy. Loss of Limbs as a result of disease process is excluded from this definition.

ABR-Critical

Please refer to the applicable fraud warning for your state of residence

Alabama, Arkansas, Arizona, Louisiana, New Hampshire, New Mexico, Rhode Island, Texas and West Virginia:

This warning is required by law to be provided on this form and it is for your protection. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines and confinement in prison.

Alaska, Kentucky, Maryland, Minnesota, Ohio and Pennsylvania:

This warning is required by law to be provided on this form and it is for your protection. A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For your protection Colorado law requires the following to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware, Idaho, Indiana and Oklahoma:

This warning is required by law to be provided on this form and it is for your protection. Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For your protection District of Columbia law requires the following to appear on this form. WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the Applicant.

For your protection Florida law requires the following to appear on this form. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Maine, Tennessee, Virginia and Washington:

This warning is required by law to be provided on this form for your protection. WARNING: It is a crime to knowingly provide false or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For your protection New Jersey law requires the following to appear on this form. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For your protection Puerto Rico law requires the following to appear on this form. Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand ($5,000) dollars and not more than ten thousand ($10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a

maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.